# Medicare Conference Agreements For Titles I - VII

## Title I Medicare Prescription Drug Benefit

### Medicare Prescription Drug Discount Card

Card Availability

- The Medicare-endorsed drug discount cards will be available no later than 6 months after enactment, and would end when the prescription drug benefit becomes available to the beneficiary in 2006. A transition provision would ensure an appropriate transition for ending the discount card and beginning the drug benefit.
- Beneficiaries would have a choice of at least two Medicare endorsed cards.
- Cards would be available on at least a statewide basis, except for Medicare+Choice sponsors who could offer cards in their service area.

Eligibility

- All Medicare beneficiaries would be eligible for the card, except those enrolled in Medicaid and entitled to Medicaid drug coverage.
- Individuals could only enroll in one Medicare-endorsed card at a time.
- In 2004, individuals may change their designated drug card for 2005.

Program Design

- There would be a continuous open enrollment for beneficiaries, and a standard enrollment form.
- The Secretary would disseminate card information, enrollment information and availability of transitional assistance to beneficiaries.
- Card sponsors could charge an annual enrollment fee of up to $30, which may be paid by a State.
- Card sponsors would offer beneficiaries access to negotiated prices.

Drug Card Sponsors

- PBMs, wholesalers, retail pharmacies, insurers, or Medicare+Choice plans could be sponsors of a Medicare-endorsed drug card.
- Sponsors must obtain approval from the Secretary in order to offer the Medicare endorsed card.
- Drug card sponsors would provide information on enrollment fees and negotiated prices for drugs.
- Sponsors must provide convenient access to pharmacies (using the TRICARE access standard).
- Drug card sponsors would administer a system to reduce medication errors and prevent adverse drug interactions.
- Sponsors would maintain a grievance process to resolve disputes.
- Sponsors are precluded from marketing non-drug products to Medicare beneficiaries.

Transitional Low Income Assistance

- All individuals with income under 135 percent of the federal poverty level would be eligible for transitional assistance unless they have third party coverage from employers, Department of Defense, Medicaid or the Federal Employees' Health Benefit Program.
- Individuals would self-certify income, but eligibility would be verified by HHS through Medicaid, the Social Security Administration or tax information, subject to strict confidentiality constraints.
- There would be no asset test (unlike Medicaid).
- Up to $600 per year would be provided in conjunction with the discount card to purchase prescription drugs, but the amount may be prorated for beneficiaries who enroll for part of a year.
- The annual enrollment fee would be paid by the Secretary.
- Eligible beneficiaries below 100% of FPL would pay a 5% coinsurance on each discounted drug; Eligible beneficiaries between 101%- 135% of FPL would pay a 10% coinsurance on each discounted drug.

**Quality Measures Related to Prescription Drugs**

Medication Therapy Management

- Plans must have programs to provide medication therapy management by pharmacy providers targeted to beneficiaries who (1) have multiple chronic conditions, (2) use multiple prescriptions and (3) are likely to incur high drug expenses.
- These programs would ensure appropriate use of prescription drugs to improve therapeutic outcomes and reduce adverse drug interactions.
- Plans must take into account medication therapy management services when determining reimbursement for pharmacists.

Electronic Prescribing

- Plans [must/may] require prescriptions to be written and transmitted electronically.
- Prescribing health providers would receive relevant information from plans on medical history, lower cost drugs, eligibility and benefits, drugs included on the formulary, and information on potential adverse drug interactions.
- [Standards would be developed by accredited bodies and submitted to the Secretary by January (2005). If no standards are reported, the Secretary must promulgate standards by September (2005). Plans would implement standards on a voluntary basis in January (2006). Mandatory adoption for plans would occur in (2007), and for health professionals in (2008).]
- Discretionary grants would be available to assist providers in implementing electronic prescription programs.

## Title II Medicare Enhanced Fee-For-Service And Medicare Advantage Programs; Medicare Competition

- Plans which serve beneficiaries with specialized needs could restrict coverage to those beneficiaries through 2007.
- Municipal health service demonstrations would be extended through 2006.
- PACE providers and individuals enrolled in PACE would receive the same balance billing protections as other Medicare+Choice plans.

## Title III Combating Waste Fraud and Abuse

- The Secretary would conduct a demonstration of recovery audit contractors in at least two states for three years to identify under or overpayments and collect overpayments.

## Title IV Rural Health Care Improvements

- Nurse practitioners will be able to continue to treat their patients who enroll in hospice programs.
- Critical Access Hospital (CAH) program would be improved, including:
    - an increase in the payment amounts to 101% of costs;
    - up to 25 beds can be used for acute care;
    - new eligibility rules that allow hospitals with no greater than 10 psychiatric or rehabilitation beds to become CAHs;
    - on-call payments to physician assistants, nurse practitioners, and clinical nurse specialists;
    - reinstate the periodic interim payments and develop alternative timing methods to achieve an appropriate level of cash flow;
    - eliminate the barrier for receiving the physician bonus; and
    - authorize $35 million a year in Rural Flexibility Grants, with 95% of the funds going to the hospitals.
- Consolidated billing is eliminated for the professional services provided by rural health clinic and federally qualified health clinic services.
- The hold harmless for hospital outpatient services performed at small rural hospitals would be extended for two years. During this time period, the Secretary will review the prospective payment system rates.
- A safe harbor is created for donations and other remuneration used to improve services at Federally Qualified Health Centers.
- Hospitals that are missing cost reports will be eligible for sole community status if one base year cost report is available.

## Title V Provisions Relating To Part A

- Medicare payments to skilled nursing facilities will be refined to reflect the high cost of treating patients with AIDS.
- A new process is established, similar to the current wage index reclassification process, based on commuting data, which would enable hospitals to receive a blended wage index amount based on the percent of employees which commute

from adjacent MSAs. [In addition, an outbound commuting proposal to account for hospital employees in a county that commute to other higher wage index areas is pending a CBO score.]

- The PPS rate for hospitals in Puerto Rico would be permanently increased to 75% of the national rate over 2 year transition.
- The Department of the Treasury would be allowed to correct a technical error regarding the HI Trust Fund.
- Hospice physicians will be reimbursed for educating patients about the program.
- The Secretary will update the weights for the hospital market basket more frequently than once every 5 years.

## Title VI Provisions Relating To Part B

- Screening tests would be covered for early detection of cardiovascular disease.
- Individuals at high risk for diabetes would be covered for laboratory screening tests.
- Mammography payments provided in hospital outpatient departments would be paid under the higher rates in the physician fee schedule.
- Certain sole source drugs in the hospital outpatient setting will be paid at least 88% of AWP in 2004 and at least 83% of AWP in 2005, but no more than 95% of AWP. Multiple source drugs would be paid no more than 68% and generic drugs would be paid no more than 46%. The General Accounting Office will collect data on hospital acquisition costs for drugs. The provision recognizes variation in the costs for brachytherapy seeds.
- An advisory board is established to provide advice for the end stage renal disease demonstrations underway by the Centers for Medicare and Medicaid Services.
- The payments for exceptionally costly care are restored for facilities that primarily treat pediatric dialysis patients.
- Podiatrists, dentists and optometrists would be included under private contracting authority.
- A fee schedule amount is established for custom shoes for diabetic patients.
- One year moratorium on the therapy cap.

## Title VII Provisions Relating To Parts A and B

- The Secretary shall conduct a demonstration to test a less restrictive home bound definition used for eligibility for home health services.
- A new open process and timelines are established for national coverage decisions. Clinical trials are covered for Category A devices.
- The Secretary shall conduct a demonstration for home health services delivered at medical adult day care centers.
- The Medicare Payment Advisory Commission will be required to examine the budgetary requirements of their recommendations. MedPAC members must fully disclose their finances. The Commission shall include at least one member with pharmaceutical expertise.